BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Rudi Unterthiner, M.D. Certificate # A-23118 Respondent.	)	No. D-3262

DECISION

The attached Stipulation is hereby adopted by the Division of Medical Quality of the Board of Medical Quality Assurance as its Decision in the above-entitled matter.

This Decision shall become effective on February 29, 1988.

IT IS SO ORDERED January 29, 1988.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

Theresa Claassen

THERESA CLAASSEN, Secretary-Treasurer

JOHN K. VAN DE KAMP, Attorney General
of the State of California
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Attorneys for Complainant

BEFORE THE

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation and First Amended and Supplemental Accusation Against: RUDI A. UNTERTHINER, M.D. 71-246 Sahara Road Rancho Mirage, CA 92270 Certificate No. A023118 Respondent.	No. D-3262 STIPULATION FOR SETTLEMENT

IT IS HEREBY STIPULATED as follows:

1. Complainant Kenneth J. Wagstaff is represented by John K. Van de Kamp, Attorney General, and Alvin J. Korobkin, Deputy Attorney General. Respondent, Rudi A. Unterthiner, M.D., is represented by Lewin and Levin, by Henry Lewin, Esquire.

2. Respondent has received and read the Accusation and

the First Amended and Supplemental Accusation on file in this matter, and fully understands the nature of the charges alleged against him.

3. Respondent is fully aware of his right to a hearing on the charges against him, his rights to reconsideration, appeal, and all other rights which may be accorded to him pursuant to the Administrative Procedure Act. Respondent freely and voluntarily waives such rights.

4. Respondent admits each and every allegation contained in the Accusation and First Amended and Supplemental Accusation, except the allegations contained in paragraphs 6(a) and 8 of the First Amended and Supplemental Accusation which are withdrawn.

5. The above waiver and admissions are made for the purposes of this stipulation only, and for no other proceedings. In the event this stipulation is not accepted and adopted by the Division of Medical Quality, said waiver and admissions are null and void and inadmissible in any future proceedings between the parties.

6. The Division of Medical Quality shall issue an order which provides as follows:

Physician and Surgeon's Certificate No. A023118 issued to respondent Rudi A. Unterthiner, M.D., shall be revoked. However, revocation is stayed and respondent is placed on probation for five years upon the following terms and conditions:

(1) Within 60 days of the effective date of this decision, respondent shall take and pass an oral

clinical examination in plastic surgery, to be administered by the Division or its designee. If respondent fails this examination, respondent must take and pass a re-examination consisting of a written as well as an oral clinical examination. The waiting period between repeat examinations shall be at three month intervals until success is achieved. The Division shall pay the cost of the first examination and respondent shall pay the cost of any subsequent re-examinations. Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Division in writing.

(2) Within 90 days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Division for its prior approval an education program or course related to plastic surgery, which shall not be less than 40 hours per year, for each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division.

(3) In addition to the requirements of condition (2) above, respondent shall take and complete a course

in Medical Ethics. Within 60 days of the effective date of this decision, respondent shall select and submit a course to the Division for its prior approval.

(4) Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California.

(5) Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

(6) Respondent shall comply with the Division's probation surveillance program.

(7) Respondent shall appear in person for interviews with the Division's medical consultant upon request at various intervals and with reasonable notice.

(8) The period of probation shall not run during the time respondent is residing or practicing outside the jurisdiction of California. If, during probation, respondent moves out of the jurisdiction of California to reside or practice elsewhere, respondent is required to immediately notify the Division in writing of the date of departure, and the date of return, if any.

(9) Upon successful completion of probation, respondent's certificate will be fully restored.

(10) If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation

and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

JOHN K. VAN DE KAMP, Attorney General
of the State of California

DATED: 9-30-87

ALVIN J. KOROBKIN,
Supervising Deputy Attorney General

Attorneys for Complainant

LEWIN AND LEVIN

DATED: 9-3-87

HENRY LEWIN, Esquire

Attorneys for Respondent

I have read the foregoing, have been advised by counsel, and agree to the terms of this stipulation.

DATED: 9-3-87

RUDI A. UNTERTHINER, M.D.

Respondent

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of the State of California
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Attorneys for Complainant

BEFORE THE

BOARD OF MEDICAL QUALITY ASSURANCE

DIVISION OF MEDICAL QUALITY

STATE OF CALIFORNIA

In the Matter of the Accusation Against: RUDI A. UNTERTHINER, M.D. 71-246 Sahara Road Rancho Mirage, California 92270 Certificate No. A023118 Respondent.	NO. D-3262 ACCUSATION

KENNETH J. WAGSTAFF alleges:

1. He is the Executive Director of the Board of Medical Quality Assurance and makes this accusation in his official capacity.

2. At all times mentioned herein respondent Rudi A. Unterthiner, M.D., was licensed by the board under Physician and Surgeon Certificate No. A023118. Said certificate is currently in full force and effect.

3. Sections 2227 and 2234 of the Business and Professions Code provide that a certificate may be suspended or revoked if the holder is guilty of unprofessional conduct. Section 2234(a) provides that violating any provision of the Medical Practice Act constitutes unprofessional conduct.

4. Section 2234(e) of the Business and Professions Code provides that the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon constitutes unprofessional conduct.

5. Respondent is subject to disciplinary action pursuant to section 2234(e) of the code in that respondent is guilty of acts of dishonesty which are substantially related to his qualifications, functions or duties as a physician and surgeon, as follows:

A. Respondent filed an application for medical staff membership and clinical privileges with Desert Hospital on or about June 21, 1976. The application for membership stated that any significant misstatements or omissions constitute cause for denial of appointment. Respondent gave untruthful answers on his application and before an hoc committee of the hospital.

B. Question 6 on the application for medical staff membership concerns affiliations and requests the applicant to list all current and previous hospital affiliations. Respondent failed to list Palmdale Community Hospital. Respondent had had conflicts with the chief of staff of Palmdale Community Hospital. The situation deteriorated to the point where respondent tore up

letters from the chief of staff without reading them. Due to chart problems, respondent's privileges were suspended at the hospital. Respondent orally resigned from the hospital.

C. Question 16 on the application asks whether the applicant's privileges at any hospital had ever been suspended, diminished, revoked or not renewed and whether the applicant had ever been denied membership or renewal thereof or been subject to disciplinary action in any medical organization. Respondent answered the question in the negative, despite having been denied staff privileges at two hospitals in Santa Barbara.

D. At an ad hoc committee hearing, respondent was asked whether he had any problems or clashes with individuals in the Lancaster-Palmdale area. Respondent stated that he did not have any specific problems. He failed to mention his problems at Palmdale Community Hospital, which he later admitted and testified to before a hearing officer. Respondent also failed to mention that he had resigned from Antelope Valley Hospital at a time when disciplinary proceedings had been initiated.

6. After various administrative hearings concerning the above and other matters pertinent to respondent's application for staff membership, the denial of his application was recommended successively by the credentials committee, the executive committee, the ad hoc committee, and a hearing officer appointed by the hospital's board of directors. The board adopted the hearing officer's recommendation.

The hearing officer determined that respondent was untruthful in the preparation and filing of his application for

staff membership, that he was untruthful in his testimony during the hearing, and that he failed to satisfy ethical standards.

Respondent filed a petition for writ of mandate to compel the hospital district to set aside its order denying him admission to its medical staff. The superior court of Riverside County granted the petition and the hospital district appealed.

On appeal, the California Supreme Court in Unterthiner v. Desert Hospital District of Palm Springs (1983) 33 Cal.3d 285, reversed the trial court's decision. The Supreme Court held that the basis of the district's decision was false statements in respondent's application and in his testimony as to lack of problems in the Palmdale-Lancaster area, and that the basic findings of falsehood were supported by undisputed evidence and were not adequately explained.

7. Respondent is further subject to disciplinary action pursuant to section 2234(e) of the Business and Professions Code, as follows:

A. In the case referred to in paragraph 6 above, there was other undisputed evidence showing a lack of veracity in relation to hospital activities.

B. Respondent did not deny that at Antelope Valley Hospital in 1976 he left in the midst of surgery when he was proctoring a doctor having only temporary privileges, that he reported that he proctored the surgery and that he completed the post-operative evaluation before the patient left the operating room.

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C. Nor did respondent claim that in Santa Barbara in 1968-1970, where he repeatedly failed to appear for scheduled surgery or appeared tardily due to his admitted moonlighting at a Los Angeles hospital, contrary to hospital rules, that he advised his mentors or associates of the true reasons for his failure to perform his assigned duties.

WHEREFORE, complainant prays that the Division of Medical Quality hold a hearing on the allegations contained herein, and following said hearing, take such action as provided by section 2227 and 2234 of the Business and Professions Code, or take such other and further action as may be proper.

DATED: October 29, 1984

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

AJK:sk:gm

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BEFORE THE

BOARD OF MEDICAL QUALITY ASSURANCE

DIVISION OF MEDICAL QUALITY

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: RUDI A. UNTERTHINER, M. D. 71-246 Sahara Road Rancho Mirage, California 92270 Certificate No. A023118 Respondent.	NO. D-3262 FIRST AMENDED AND SUPPLEMENTAL ACCUSATION

Complainant, Kenneth J. Wagstaff, alleges:

1. Complainant repleads and realleges each and every allegation contained in the original Accusation.

2. Section 2234(b) of the Business and Professions Code provides that unprofessional conduct includes gross negligence.

3. Section 2234(d) of the Business and Professions Code provides that unprofessional conduct includes incompetence.

4. Section 2261 of the Business and Professions Code provides that knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

5. Section 726 of the Business and Professions Code provides that the commission of any act of sexual abuse, misconduct or relations with a patient, client or customer which is substantially related to the qualifications, functions or duties of the occupation for which a license was issued constitutes unprofessional conduct and grounds for disciplinary action.

6. Respondent is subject to disciplinary action pursuant to section 2234(b) of the Business and Professions Code in that respondent is guilty of gross negligence, as follows:

A. Patient Barbara J.

On or about June 1, 1983, respondent performed a facelift and upper eye lid surgery upon patient Barbara J. Discoloration was present on the left and right side of the patient's face postoperatively on June 1, June 2, June 4, and June 6. Respondent then left the country. Respondent is guilty of gross negligence in that he failed to arrange for another plastic surgeon to be available to provide postoperative care for the patient during his absence. The patient suffered complications and emotional distress during the respondent's absence.

B. Patient Shirley N.

On or about April 6, 1983, respondent performed a facelift and upper eye lid surgery upon patient Shirley N. The patient suffered excessive scarring and disfigurement on the left side of her face and neck. Respondent is guilty of gross negligence in that:

(1) Respondent failed to perform a forehead lift, which she was promised and which she paid for.

(2) Respondent failed to properly control the bleeding which occurred in the patient's left cheek area, and failed to properly evacuate the hematoma which subsequently formed in the patient's left cheek area. As a result, the patient developed excessive scarring which extended on to the cheek and neck skin in areas where there is customarily no visible scar, and she was left with disfigurement of the left side of the face.

(3) Respondent failed to maintain adequate and reliable medical records detailing the patient's postoperative condition.

(4) On or about June 1983, respondent left the country without arranging for another plastic surgeon to be available to provide postoperative care for this patient during his absence.

C. Patient John Q.

On or about December 14, 1983, respondent performed limited facelift surgery upon patient John Q. Almost

immediately, the patient experienced excessive bleeding, resulting in swelling and discloration which lasted for several days. On December 28, 1983, the patient was admitted to a hospital suffering from bleeding, congestive heart failure, staph infection and necrotic skin flaps. Respondent is guilty of gross negligence in that:

(1) Respondent failed to allow sufficient time prior to surgery for the patient to receive treatment with an antibacterial detergent.

(2) Respondent failed to allow sufficient time prior to the surgery for the patient, who was 82 years old and a high risk patient, to reflect on the wisdom of going forward with the surgery. Respondent first saw the patient on December 13, 1983, one day prior to the surgery.

(3) Respondent failed to properly obtain hemostasis during or after the surgery.

(4) Respondent failed to properly monitor the patient's bleeding following surgery, failed to have any blood studies performed, and failed to return the patient to the operating room to remove the blood and obtain hemostasis.

(5) Respondent failed to properly control the bleeding which occurred in the patient's left side of the face, and failed to properly evacuate the hemotoma which subsequently formed. As a result, the patient experienced necrosis of the skin flaps.

(6) Respondent failed to recognize that the patient developed congestive heart failure subsequent to the surgery.

(7) Respondent failed to prescribe optimal dosage of an appropriate antibiotic for the patient's staphylococcal infection.

(8) Respondent failed to document in his medical records that the patient suffered from excessive postoperative bleeding, accumulated substantial fluid below the skin flap, and experienced necrosis of the skin flaps.

(9) Respondent failed to maintain a beeper where he could be reached if necessary.

D. Patient Mary C.

On or about August 30, 1976, respondent performed facelift and upper eye lid surgery upon patient Mary C. A postoperative hematoma developed which led to necrosis of the underlying skin, tissue slough and a hypertropic scar and contracture beginning at the left ear lobe and extending along the posterior border of the mandible and down into the neck. Respondent is guilty of gross negligence in that:

(1) Respondent failed to observe the patient for approximately 72 hours following the surgery, during which time the complications had already begun to develop. Said complications would have been visible and apparent to respondent had he observed the patient during this time period.

The evening following surgery the patient told respondent on the telephone she was experiencing pain and pressure on the left side of her face.

(2) When respondent finally did see the patient postoperatively on September 2, 1976, respondent failed to properly diagnose the complications from the facelift surgery and failed to take appropriate action to treat those complications.

(3) Respondent failed to document in his medical records the complications which developed from the facelift surgery

(4) Respondent's management and treatment of this patient reflects a lack of knowledge and ability in routine postoperative facelift care and an inability to recognize and deal with complications from facelift surgery.

E. Patient Verbena A.

On or about September 24, 1976, respondent performed a facelift and eye lid surgery upon patient Verbana A. Postoperative complications developed which resulted in prominent left facial scarring and cheek tissue slough. Respondent is guilty of gross negligence in that:

(1) Respondent failed to document in his medical records the complications which developed, the cause of those complications, or the respondent's plan for treating the complications.

(2) Respondent failed to recognize or treat the patient's postoperative complications from the facelift.

7. By reason of the matters alleged in paragraph 6A through 6E inclusive, respondent is guilty of incompetence and subject to disciplinary action pursuant to Business and Professions Code section 2234(d).

8. Respondent is subject to disciplinary action pursuant to section 726 of the Business and Professions Code in that he is guilty of an act of sexual abuse, misconduct or relations with a patient which is substantially related to the qualifications, functions or duties of the practice of medicine, as follows:

At the conclusion of the surgery performed on patient Shirley N. referred to in paragraph 6B above, respondent manipulated patient Shirley N.'s vaginal area with his finger or fingers.

9. Respondent is subject to disciplinary action pursuant to section 2261 of the Business and Professions Code in that respondent is guilty of knowingly making or signing documents related to the practice of medicine which falsely represent the existence or nonexistence of a state of facts, as follows:

Patient Shirley N.

Respondent falsified his medical records for patient Shirley N. in order to conceal the true nature of the complications from her surgery. During the period of time after

surgery that the hematoma had developed and would have been plainly visible, respondent was omitting any reference to the problem in the patient's medical records; instead, respondent was making entries such as "no problems" and "looks ok." Respondent later attempted to falsely blame the complications on undue pressure due to sleeping on the left side.

Patient John Q.

Respondent falsified his medical records for John Q. in order to conceal the true nature of the complications from his surgery. While postoperative complications on December 14, 1983, resulted in excessive bleeding and efforts to control the patient's bleeding, respondent was omitting any reference to the problem in the patient's medical records; instead, respondent indicated in said records that all went well with "no problems." In addition, respondent made an entry on December 28, 1983, that the patient was "healing well;" in truth and in fact, the patient was suffering from considerable swelling, which is reflected in his hemoglobin dropping from 14.4 gms prior to surgery to 8.9 gms two weeks later. These medical records reflect a pattern of obfuscation and denial on the part of the respondent. The inaccuracy of those medical records was of such a degree as to make those records almost useless as a reliable indicator of the patient's condition.

Patient Mary C.

Respondent falsified his medical records for Mary C. in order to conceal the true nature of the complications from her surgery. During the period of time after surgery that

respondent was aspirating the hematoma which had developed and prescribing antibiotics to fight possible infection, he was omitting any reference to the problem in the patient's medical records; instead, respondent was making entires such a "healing very well" and "no problem at all" in those medical records. Respondent later attempted to falsely blame the patient's tissue loss and subsequent scar on an ear infection spilling infectious material onto the patient's face.

Patient Verbena A.

Respondent falsified his medical records for Verbena A. in order to conceal the true nature of the complications from her surgery. Respondent omitted any reference to the true causes of those complications. Respondent later attempted to falsely blame the patient's scarring and tissue loss on an infection caused by food spoilage through intact skin.

WHEREFORE, Complainant prays that the Division of Medical Quality hold a hearing on the allegations contained in the original Accusation and the First Amended and Supplemental Accusation and, following said hearing, take such action as provided by sections 2227 and 2234 of the Business and Professions Code, or take such other and further action as may be proper.

DATED: September 12, 1986

KENNETH J. WAGSTAFF
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

AJK:cb:gm